



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Buena Vista Workskills 5445 La Sierra Dr. #204 Dallas, TX 75231	MFDR Tracking #:	M4-06-4914-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: North East ISD Rep. Box # 16	Date of Injury:	
	Employer Name:	
	Insurance Carrier:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Services were preauthorized: 2004032."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Total Amount Sought - \$809.22

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Reference EOB's dated :05/09/05 and 03/24/06. Following statement by Carrier applicable to all dates of service and service in dispute: Carrier's primary rationale for maintaining denial of payment is W-12 'Extent of injury. Not finally adjudicated.' Carrier's position remains unchanged. Carrier's position is that care in dispute is directed to conditions unrelated to the compensable injury. Carrier clearly notified the provider (orally & in writing) at the time the preauthorization determination was issued. Regarding CPT 90880 for all dates of service: Carrier maintains that CPT 90880 (Hypnotherapy) is a modality of psychotherapy and is subject to preauthorization."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	CPT Code(s) and Calculations	Denial Codes	Part V Reference	Amount Due
4-4-05	90806	W12, 151, 150	1-4	\$359.25
4-11-05	90880	W12, 62	1, 2, 5	\$0.00
5-6-05				
Total Due:				\$359.25

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

1. These services were denied by the Respondent with reason code "W12-Extent of injury. Not finally adjudicated; 62-Payment denied/reduced for absence of, or exceeded, pre-certification/authorization; 151-Payment adjusted because the payer deems the information submitted does not support this many services; and 150- Payment adjusted because the payer deems the information submitted does not support this level of service."
2. The claimant sustained a compensable lumbar injury on 12-18-01.
3. A review of the submitted CMS-1500 indicates that the disputed treatment was for the diagnosis of 724.4 – Thoracic/lumbosacral neuritis/radiculitis.
4. From 4-4-05 thru 5-6-05, the Requestor billed three (3) dates of CPT code 90806-Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient. The Requestor submitted reports that supported billing for one (1) hour of treatment. The MAR for CPT code 90806 in Bexar County is \$119.75. This amount times 3 dates = \$359.25. The Respondent paid \$0.00. The difference between MAR and amount paid = \$359.25, this amount is recommended.
5. From 4-4-05 thru 5-6-05, the Requestor billed three (3) dates of CPT code 90880-Hypnotherapy. The Respondent denied reimbursement based upon lack of preauthorization. Per Rule 134.600 effective 3-14-04, preauthorization is required for (h) "all psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program. The Requestor did not submit a written preauthorization report to support service was preauthorized; therefore, no reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of \$359.25 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER / DECISION:


Authorized Signature


Medical Fee Dispute Resolution Officer

May 8, 2008
Date

[REDACTED]

[REDACTED]

[REDACTED]

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

